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Ivan R. Romash,Vasyl Ye. Neyko, Iryna B. Romash, Kateryna V. Dzivak, Petro R. Gerych, Mykhaylo V. Panchyshyn, Olesya M.Gerych, Mykhaylo M. Pustovoyt.
Ivano-Frankivsk National Medical University (Ivano-Frankivsk, Ukraine)
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POST-TRAUMATIC STRESS DISORDER AS A NOSOLOGICAL UNIT: DIFFICULTIES OF THE PAST AND CHALLENGES OF THE FUTURE

ABSTRACT

Introduction. The impact of traumatic experiences has always been a part of human life. According to Judith Herman, an American psychotherapist, and professor at Harvard Medical School, "traumatic events overload a person's usual strategies for adapting to life, his usual security systems that give a sense of control, connection, and meaning." Also, traumatic events, for the most part, contain close personal contact with violence and death and pose a threat to life or physical integrity. For almost one year of the war, Ukrainian society faced a large number of negative phenomena capable of causing severe psychological trauma: disruption of the usual lifestyle, loss of family friends, and property, lack of many vital needs for a person, forced migration, uncertainty, a constant threat for health and life, etc.

The purpose of the study was to analysis of scientific and literary data reflecting the history of the formation of the concept of "post-traumatic stress disorder" as a nosological unit, as well as the peculiarities of its manifestation and prevalence, diagnostic criteria.

Materials and methods: A systematic search was conducted in the main electronic medical databases, such as PubMed, Scopus, Web of Science, Google Scholar, and processed publications that studied the history of the formation of "post-traumatic stress disorder" as a nosological unit, the features of its manifestation and prevalence. diagnostic criteria. Eligible studies were identified using keywords: post-traumatic stress disorder, psychotraumatology, trauma, physioneurosis, history of medicine. All types of articles were reviewed, including original studies, systematic reviews, and meta-analyses.

Review and discussion: For a long time, there was a stigmatization of combat-related disorders in society. The path to the development of PTSD as a psychiatric diagnosis is long and thorny. After the World War II, there was an urgent need to introduce a standard unified nomenclature that would enable doctors from all over the world to have a common language for discussing the psychopathology of this disorder, establishing a diagnosis and determining disability. Over 60 years, starting in 1952, when the American Psychiatric Association (APA) introduced the concept of "brutal stress reaction" in its first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) and up to 2013 (DSM-5) formation of post-traumatic stress disorder as a nosological unit was taking place.

Conclusions: Despite the non-acceptance, stigmatization, indifference and other difficulties, PTSD finally achieved official status in the recognized list of diagnoses.

KEYWORDS

traumatic stress, post-traumatic stress disorder, psychotraumatology, physioneurosis, history of medicine.

CORRESPONDING AUTHOR INFORMATION

Ivan R. Romash
MD, Ph.D., Associate professor of The Department of Psychiatry, Narcology and Medical Psychology.
Ivano-Frankivsk National Medical University, Ukraine.
st. Pylyp Orlyk 5/7. 76010. Ivano-Frankivsk. Ukraine.
https://orcid.org/0000-0002-6591-6613
e-mail: iromashr@gmail.com

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INTRODUCTION

The impact of traumatic experiences has always been a part of human life. According to Judith Herman, an American psychotherapist, and professor at Harvard Medical School, "traumatic events overload a person's usual strategies for adapting to life, his usual security systems that give a sense of control, connection, and meaning." Also, traumatic events, for the most part, contain close personal contact with violence and death and pose a threat to life or physical integrity. (Herman, 2022).

For almost one year of the war, Ukrainian society faced a large number of negative phenomena capable of causing severe psychological trauma: disruption of the usual lifestyle, loss of family friends, and property, lack of many vital needs for a person, forced migration, uncertainty, a constant threat for health and life, etc. (Perrotta, 2019; Rosen, Ayers, 2020).

It is known that the behavior of people in war conditions is determined by two groups of behavioral patterns: some become soldiers, volunteers, defenders in the broadest sense of the word, and others become refugees, evacuees. Both are at risk of developing post-traumatic stress disorder (PTSD), so they need

psychological support and help (Prydybailo, Murza, Sadova, 2022).

Currently, traumatic and stress disorders have become separate nosologies, different from anxiety disorders. This is because many such patients do not have anxiety but instead suffer from anhedonia, dysphoria, anger, aggression, or dissociation. Also, in the field of diagnosis of stress disorders, in particular, PTSD, they stopped focusing exclusively on the concept of fear, as it was before. It has been scientifically proven that many patients with PTSD, in addition to fear, show many other emotional reactions unrelated to it.

Two well-known types of PTSD are acute stress disorder (ASD) and PTSD. ASD usually begins immediately after experiencing a devastating traumatic event, characterized by a short period of intrusive memories that occur, on average, within 4 weeks (from 3 days to 1 month). In turn, PTSD is a recurring, unwanted, debilitating recollection of a devastating traumatic event that occurs as a continuation of PTSD or as an independent disorder that develops over time up to 6 months after experiencing the last one and lasts for more than a month. Common causes of PTSD include combat, sexual and other physical or mental violence, natural disasters, man-made disasters, pandemics, etc. Traumatic events can cause changes in physiological tone, emotions, perception, and memory (Herman, 2022).

The main syndromes of this disorder include: intrusion (involuntary, obsessive, repetitive, and depressing disturbing memories, dreams, flashbacks), avoidance (avoidance of thoughts, feelings, actions, places, and memories associated with the event), negative changes in cognitive functions and moods (dissociative amnesia, self-blame, detachment, alienation, emotional "dullness") and changes in excitability and reactivity (mood instability and self-destructive behavior, alertness, confusion, sleep problems).

Thus, the many symptoms of PTSD fall into three main categories: hyperarousal, intrusion, and constriction. At the same time, hyperarousal reflects a constant expectation of danger, the intrusion is an indelible imprint of a traumatic moment, and constriction is a reaction of numbness and surrender. It is obvious that such syndromes and their symptoms significantly worsen the social and professional functioning, and therefore the quality of life of the victim. It should be noted here that the International Classification of Functioning, Disability, and Health (ICF) recognizes functioning as the most important component of health and well-being. In particular, the ICF emphasizes the importance of ensuring adequate social functioning for all people, regardless of mental or physical condition (WHO, 2001; Romash, Vynnyk, 2019).

The main factors, the combination of which leads to the occurrence of PTSD can be divided into three groups: the intensity of the traumatic event, its duration, unexpectedness, and uncontrollability; the strength of the individual's protective mechanisms and the presence of social support; personal risk factors: age at the time of traumatic events, presence of traumatic events and mental disorders in previous periods of a person's life (Al Jowf, Ahmed, An, Reijnders, Ambrosino, Rutten, de Nijs, 2022).

Unfortunately, the pathophysiology of this disorder is currently not fully understood. A body of evidence accumulated over several decades supports the neurobiological nature of PTSD. Separate scientific data help to understand the pathophysiology of PTSD, as well as the biological vulnerability of certain population groups to the development of PTSD. (Sherin, Nemeroff, 2011).

PURPOSE

The purpose of the study was to analysis of scientific and literary data reflecting the history of the formation of the concept of "post-traumatic stress disorder" as a nosological unit, as well as the peculiarities of its manifestation and prevalence, diagnostic criteria.

METHODOLOGY

A systematic search was conducted in the main electronic medical databases, such as PubMed, Scopus, Web of Science, Google Scholar, and processed publications that studied the history of the formation of "post-traumatic stress disorder" as a nosological unit, the features of its manifestation and prevalence. diagnostic criteria. Eligible studies were identified using keywords: post-traumatic stress disorder, psychotraumatology, trauma, physioneurosis, history of medicine. All types of articles were reviewed, including original studies, systematic reviews, and meta-analyses.

REVIEW and DISCUSSION

For a long time, there was a stigmatization of combat-related disorders in society. The path to the development of PTSD as a psychiatric diagnosis is long and thorny. After the World War II, there was an urgent need to introduce a standard unified nomenclature that would enable doctors from all over the world to have a common language for discussing the psychopathology of this disorder, establishing a diagnosis and determining disability. Over 60 years, starting in 1952, when the American Psychiatric Association (APA) introduced the concept of "brutal stress reaction" in its first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) and up to 2013 (DSM-5) formation of post-traumatic stress disorder as a nosological unit was taking place. But despite the non-acceptance, stigmatization, indifference and other difficulties, PTSD finally achieved official status in the recognized list of diagnoses.

The impact of traumatic experiences has always been a part of human life. According to Judith Herman, an American psychotherapist, and professor at Harvard Medical School, "traumatic events overload a person's usual strategies for adapting to life, his usual security systems that give a sense of control, connection, and meaning." Also, traumatic events, for the most part, contain close personal contact with violence and death and pose a threat to life or physical integrity. (Herman, 2022).

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Features of the prevalence of post-traumatic stress disorder.

According to statistics, 90% of people are exposed to one or another traumatic event during their lifetime, but only about 5-10% of the general population suffers from PTSD (Banerjee, 2017). In particular, recent data suggest that about 4% of American men and 10% of American women will be diagnosed with PTSD during their lifetime. It is important to note that while this condition affects approximately 10% of the American civilian population during their lifetime, it is approximately 14-16% among military personnel (Hipes, Gemoets, 2019).

The National Vietnam Veterans Readjustment Study found that the prevalence of PTSD was 15.2% among male veterans and 8.5% among female veterans. According to data from another large-scale study, the lifetime prevalence of PTSD was 30.9% among male veterans and 26.9% among female veterans. One more population-based study of Vietnam veterans reported a prevalence of PTSD of 2.5% among male veterans and 1.1% among female veterans.

Shalev AY and other members of the International Consortium for the Prediction of PTSD analyzed data from ten longitudinal studies involving 2,473 civilians from six countries who experienced traumatic events and were hospitalized in emergency centers. Therefore, the prevalence of PTSD among the examined varied within 11.8% (9.2% for men and 16.4% for women) (Shalev, Gevonden, Ratanatharathorn, Laska, Van Der Mei, Qi, 2019).

Until 2015, Ukraine had no official data on the state of mental health of servicemen. According to the data of Bogomolets OV and co-authors, the share of PTSD among military personnel who served in the anti-terrorist operation (ATO) in 2016 was more than 27% (Bogomolets, Pinchuk, Ladyk-Bryzgalova, 2016). As a result of research carried out by Blinov OA, 19% of soldiers who took part in military operations, but did not suffer physical trauma, suffered from PTSD. Subthreshold symptoms of PTSD were also diagnosed in 11% of cases. Incomplete clinical manifestations of this disorder were found in 8% of the examined. At the same time, PTSD was

found in 46% of their wounded brothers. Another 13% of combatants required additional examination for PTSD. The same researchers established a positive correlation between age and the level of combat stress. The length of stay in the combat zone is also of great importance. Scientists have established that the highest level of the potential of psychological resources in combatants is present for up to 3 months. If servicemen stay on the battlefield longer, it contributes to emotional and professional burnout. The critical level is the limit of 24 months, after which professional deformation of the personality is likely, and the risk of developing stress disorders and psycho-somatic diseases increases (Blinov, 2018). According to Pascal Brillon, psychological trauma causes the development of PTSD in about 25%-35% of cases. The population of Ukraine as of January 1, 2022, was 34.5 million. Of them Zaporizhzhia region. 1.6 million, Kherson 1 million., Donetsk 4 million, Luhansk 2.1 million. These are the regions where the most active hostilities are taking place and the approximate number of people with PTSD, including military personnel, will be about 2.1-3 million people.

The data presented are very different from each other. Numerous scientific studies show that individual vulnerability and resilience are key factors to consider in the pathology of PTSD. There are also scientific data that show that from 30 to 72% of the susceptibility to PTSD is due to heredity, in particular, certain features in the metabolism of certain neurotransmitters and hormones. It is important to note that under conditions of genetic predisposition, stress experienced in childhood caused by one or another traumatic event is also a risk factor for the development of depression and PTSD in older age (Banerjee, Morrison, Ressler, 2017).

In addition, recent data on the central nervous system (CNS) regulation indicate that the peptidergic system of the brain is a highly integrated complex whose neurons almost always express more than one neuropeptide, while each of them exerts pleiotropic effects on the CNS.

The history of the formation of the concept of post-traumatic stress disorder as a nosological unit.

The history of what is now called PTSD is often linked to combat. Stories about psychological symptoms after military trauma date back to ancient times. For the first time, the description of the symptoms of PTSD is presented in one of the oldest literary works of mankind, in the poem "About the One Who Saw Everything." The work itself, its second name "The Epic of Gilgamesh", was created over fifteen thousand years, based on Sumerian stories. This is a kind of anthem of friendship. According to scientific data, the sources date back to the 7th century BC. and were written in cuneiform on 12 six-column clay tablets, and some stories are dated to the end of the first half of the 3rd millennium BC. e. After the main character Gilgamesh loses his best friend Enkidu, he feels boundless despair, symptoms of grief, longing. This encounter with death changed his personality. The main character wants to return his friend by all possible means and understand what death is. He begins to realize his helplessness and that death inevitably happens to everyone.

The first descriptions of the guest response to stress were described by the Greek historian Herodotus in 440 BC in Book VI "History", talking about the behavior caused by the sudden fright of the Persian army on the battlefield during the Battle of Marathon (Crocq, 2000).

Homer also wrote about traumatic experiences and the symptoms that followed them in his works "Iliad" and "Odyssey", William Shakespeare - "Henry IV", Charles Dickens - "A Tale of Two Cities", etc. The first official medical attempts to help solve the problems of military veterans who experienced combat began to appear during the American Civil War (1861-1865) and the Franco-Prussian War (1870-1871). In particular, during the Civil War in the USA, surgeon Mendos Da Costa (J.M. DaCosta) observed cardiac disorders in veterans characterized by chest pains, tachycardia, difficulty breathing in combination with breathing disorders, irritability, unpleasant dreams, calling this condition "Da Costa syndrome" or "soldier's heart", a syndrome that arose from the hardships of military service. Later, in 1971, the scientist clearly described the clinical picture of this syndrome, and later it received the name somatoform autonomic dysfunction (F45.3 according to ICD-10.). Combat stress itself was also known by the names "melancholia without delirium", "neurasthenic psychosis", "nervous exhaustion", "mental wounds received in battle", "armed shock", "military neurosis", "combat fatigue", etc (Blinov, 2018). For the first time, the attention of mental health specialists, in particular psychologists and psychiatrists, was drawn to a specific mental disorder among soldiers during the First World War. At that time, some of the symptoms of modern PTSD, such as panic and sleep problems, were considered a reaction to the explosions of artillery shells and were called the terms "armed shock", and "military neurosis". For a long time, it was believed that the main cause of such symptoms is hidden damage to the brain due to contusion caused by the blast wave. The fallacy of such an opinion was confirmed when more and more soldiers, far from the explosions, had similar symptoms.

Clinical and theoretical attempts to describe the nature of combat mental trauma.

German psychiatrist Emil Kraepelin discovered that mental traumas leave behind stable disorders that progress over time. The main manifestations of these disorders were noted by Kegle, and later clarified by R. Grinker, A. Kardiner, and other researchers during and after the Second World War. American psychiatrist and psychoanalyst Abram Cardiner introduced the term "chronic military neurosis", emphasizing its psychophysiological nature. It was A. Kardiner who first managed to convey the essence of traumatic stress, presenting it as an inseparable combination of psychological and biological patterns and calling it "physioneurosis". This scientist was the first to carry out a comprehensive description of symptoms: excessive excitability and irritability; intense reaction to sudden stimuli, trauma fixation; avoidance of reality, and tendency to uncontrolled aggressive reactions. Kardiner regarded these symptoms as the consequences of chronic excitation of the autonomic nervous system. Roy Grinker and John Spiegel believed that injured

soldiers "suffer from chronic stimulation of the sympathetic nervous system." In the monograph "Man under stress" R. Grinker and J. Spiegel (1945) listed the symptoms of "acute combat reaction" in American soldiers and "military neurosis" in prisoners of war. They also studied the factors of hereditary predisposition to mental disorders and described the psychosomatics of combating mental trauma. Her symptoms included fatigue, aggression, depression, memory impairment, sympathetic nervous system hyperactivity, impaired concentration, alcoholism, nightmares, phobias, and suspiciousness. In 1941, Abram Kardiner published the data of a clinical and theoretical study in his scientific work "Traumatic neuroses of wartime". The main concept of A. Kardiner was that the psychological problems of veterans caused by the war "... are caused by a decrease in internal resources, so they begin to perceive the outside world as hostile" (Blinov, 2018). At one time, A. Kardiner notes that the topic of neurotic disorders caused by the consequences of military actions is episodic, and depends on the whims of society and psychiatric fashion. And he was also outraged by the fact that there was no consistency and continuity among scientists in the study of this issue. Every researcher interested in this topic tried to start its study from scratch, and not go further, "standing on the shoulders of titans." Thus, episodicity rather than continuity has been inherent in the field of PTSD studies.

Stages of formation of the diagnostic concept of PTSD.

For a long time, the Department of Veterans Affairs did not recognize PTSD as a diagnosable disorder. A systematic, large-scale study of the long-term impact of the combat environment on the psychological and mental state of soldiers began only after the Vietnam War, and PTSD as a nosological unit was described only ten years after it. Following the end of the above hostilities, the US Department of Veterans Affairs commissioned a scientific study designed to examine the impact of wartime experiences on the lives of veterans. The results of the research were presented in a five-volume work, which described in detail the symptoms of the mental disorder, which later received the name - PTSD. The data obtained during the study demonstrated a direct correlation between PTSD and combat trauma. This greatly influenced the creation of the diagnostic concept of PTSD.

The path to the development of PTSD as a psychiatric diagnosis is long and thorny. After the Second World War, there was an urgent need to introduce a standard unified nomenclature that would enable doctors around the world to have a common language for discussing psychopathology, establishing diagnoses, and defining disability (Andreasen, 2011). In its first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I), dated 1952, the American Psychiatric Association (APA) cites the concept of "brutal stress response." Her description emphasized that the disorder is a reaction to a strong or unusual stressor that has caused overwhelming fear in a healthy individual. It emphasized that the disorder was temporary and reversible; if the symptoms persisted, "delayed" for longer than six months, a differential diagnosis was made and a diagnosis was

sought. And even 16 years later, DSM-II (1968) did not have a diagnosis that was linked to a traumatic event. At the time, the concept was thought to be inextricably linked to war, and so apparently it was dropped entirely from DSM-II, published 23 years after the last Great War and during a period of relative peace. Thus, the concept of "reaction to gross stress" disappeared, and "reaction of adaptation to adult life" appeared. At the time, this diagnosis was limited to rather diverse examples of trauma: unwanted pregnancy with suicidal ideation, fear associated with military combat, and Hanser syndrome in prisoners facing the death sentence.

Just in 1980, according to the National Institute of Mental Health, the term PTSD became a household name when it first appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published by the APA. This became possible thanks to large-scale scientific research with the participation of Vietnam War veterans. Based on the obtained data, scientists were able to prove the connection between war trauma and post-war civilian life. Thus, the diagnosis of PTSD filled an important gap in psychiatry, and its main cause was the result of traumatic events experienced by the person and not a personal weakness. In 1987, a group of researchers led by M. Horovyts developed diagnostic criteria for PTSD (APA, 1980). The DSM-III criteria for PTSD were revised in DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-5 (2013), indicating ongoing research in this area. In particular, DSM-III-R added information about traumatic reactions observed in veterans of the Second World War and the Korean War (Moon Yong Chung, 2005). And after the publication in 1993 of data from nationwide studies of postwar adaptation of Vietnam War veterans (Kulka R. A. et al., 1990), the diagnostic criteria for acute stress disorder (ASD) and PTSD were clarified and reflected in the new edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-IV). This was the path of study and development of psychotraumatology: from traumatic shock and military neurosis to post-traumatic stress disorder:

In 1995, the diagnostic criteria of ASD and PTSD were included in the tenth edition of the International Classification of Diseases (ICD-10) - the main diagnostic standard of European countries - under the rubric F4, which unites mental disorders, the main cause of which is mental trauma (conflict, psychological stress).

An important change in DSM-5 is that PTSD is no longer an anxiety disorder. PTSD is sometimes associated with other mood conditions (such as depression) and with anger or reckless behavior rather than anxiety. Thus, PTSD now falls under a new category, Trauma and Stress Disorders. This disorder includes four different types of symptoms: re-experiencing the traumatic event (also called re-experiencing or intrusion); avoiding situations that remind of the event; negative changes in beliefs and feelings; and feeling tense (also called hyperarousal or overreacting to situations). Most people experience some of these symptoms after a traumatic event, so PTSD is not diagnosed unless all four types of symptoms last for at least a month and cause significant distress or problems with daily functioning.

Also, such a new concept as complex PTSD appears in ICD-11. The

main diagnostic criteria for this disorder are the mandatory presence of the main symptoms of simple PTSD plus subjective feelings of impaired self-identification, emotional regulation, and constant difficulties in relationships. According to scientific evidence, this condition is most often seen in individuals who have experienced severe trauma, such as torture, or experienced long-term childhood trauma, such as prolonged abuse. In such persons, the memory of the experienced fear caused by a traumatic event, under the influence of consolidation, acquires a qualitatively new state, under such conditions memories are characterized by sensitization and generalization. In contrast to PTSD, the stressors associated with PTSD are typical interpersonal factors that result from human maltreatment rather than natural disasters (Banerjee, Morrison, Ressler, 2017; Bisson, 2019). In addition to the typical symptoms of PTSD, PTSD is characterized by more persistent, long-term problems in affective functioning, self-functioning, and relationships. (Bisson, 2019).

CONCLUSIONS

Therefore, there are currently two main documents that guide professionals to diagnose PTSD: DSM-5 (APA) and ICD-11 (APA, 2013; World Health Organization, 2018). It should be noted that, more than ever before, scientists from the US National Institute of Mental Health and experts from the World Health Organization tried to maintain or even strengthen the consistency of the methodology of both classifications. Significant changes in DSM-5 were driven by new research in psychiatry and neuroscience. The authors of DSM-5 tried to group mental disorders taking into account not only the data on psychopathology, but also the achievements of neuroscience. According to the requirements of the DSM-5, a prerequisite for the diagnosis of PTSD is the presence of a patient's history of a severe traumatic life-threatening event (Criterion A) and at least one recurrent experience (Criterion B), three symptoms of avoidance/numbing (Criterion C), and two symptoms of hyperarousal (criterion D). To minimize the pathologizing of normal stress responses, victims should exhibit these symptoms for more than one month after exposure to the trauma.

It should be noted that the ICJ approach to making psychiatric diagnoses is simpler, taking into account the limited time and resources of clinicians. The newly approved ICD-11 guidelines strategically narrowly focus on fear schema symptoms, including re-experiencing the traumatic event, avoiding reminders, and perceiving heightened current threats (represented by various forms of arousal). Central to this definition is the assumption that a core component of PTSD is re-experiencing memories of a past traumatic event.

According to scientific data, ICD-11 improved the quality of diagnosis of PTSD compared to DSM-5, although to date few studies are comparing the diagnostic capabilities of DSM-5 and ICD-11. Most early studies indicated higher rates of PTSD using DSM-5 criteria, except for a large epidemiological survey that found no significant difference in prevalence estimates calculated using both

systems (Al Jowf, Ahmed, An, Reijnders, Ambrosino, Rutten , de Nijs, 2022).

Thus, despite the lack of acceptance, stigmatization, indifference and other difficulties, PTSD has finally achieved official status in the recognized list of diagnoses.

CONFLICT OF INTEREST

The Authors declare no conflict of interest.

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Ромаш Іван Романович,

Нейко Василь Євгенович,
Ромаш Ірина Богданівна,
Дзівак Катерина Володимирівна,
Герич Петро Романович,
Панчишин Михайло Володимирович,
Герич Олеся Михайлівна,
Пустовойт Михайло Михайлович

Івано-Франківський національний медичний університет. Івано-Франківськ, Україна.

ORCID ID 0000-0002-6591-6613 iromashr@gmail.com
ORCID ID 0000-0002-6033-2387 neikovasyl1959@ukr.net
ORCID ID 0000-0002-9749-778 romash_ira@ukr.net
ORCID ID 0000-0002-3481-9482 katydzivak@ukr.net
ORCID ID 0000-0002-7708-2150 pgerych@ifnmu.edu.ua
ORCID ID 0009-0000-8727-1177 panchyshyn_my@ifnmu.edu.ua
ORCID ID 0000-0001-6224-2345 Olesya-ff@ukr.net
ORCID ID 0000-0001-8689-6220 pmm2109@gmail.com

ПОСТТРАВМАТИЧНИЙ СТРЕСОВИЙ РОЗЛАД ЯК НОЗОЛОГІЧНА ОДИНИЦЯ: ТРУДНОЩІ МИНУЛОГО ТА ВИКЛИКИ МАЙБУТНЬОГО

Метою статті було здійснення аналізу наукових та літературних даних, що відображають історію становлення поняття «посттравматичний стресовий розлад» як нозологічної одиниці, а також особливості його прояву та поширеності, критерії діагностики.

Матеріали та методи: Був проведений систематичний пошук по основних електронних медичних базах даних, таких як PubMed, Scopus, Web of Science, Google Scholar та опрацьовані публікації, які вивчали історію становлення «посттравматичного стресового розладу» як нозологічної одиниці, особливості його прояву та поширеність, критерії діагностики. Відповідні дослідження були визначені за ключовими словами: посттравматичний стресовий розлад, психотравматологія, травма, фізіоневроз, історія медицини. Опрацьовували усі типи статей, включаючи оригінальні дослідження, систематичні огляди та мета-аналізи.

Результати та обговорення: Довгий час у суспільстві існувала стигматизація розладів, спричинених бойовими діями. Шлях становлення ПТСР, як психіатричного діагнозу, тривалий та тернистий. Після Другої Світової Війни назріла гостро потреба запровадження стандартної уніфікованої номенклатури, яка б дала можливість лікарям усього світу вести спільну мову для обговорення психопатології даного розладу,

встановлення діагнозу і визначення інвалідності. Понад 60 років, починаючи із 1952, коли у своєму першому випуску Діагностичного і статистичного посібника із психічних розладів (DSM-I) Американська психіатрична асоціація (APA) наводить поняття «реакція на грубий стрес» і аж до 2013 року (DSM-5) відбувалося становлення посттравматичного стресового розладу як нозологічної одиниці.

Висновки: Не зважаючи на несприйняття, стигматизацію, байдужість та інші труднощі, ПТСР нарешті домігся офіційного статусу в визнаному переліку діагнозів.

КЛЮЧОВІ СЛОВА

стрес, травматичний стрес, посттравматичний стресовий розлад, психотравматологія, фізіоневроз, історія медицини.

ІНФОРМАЦІЯ ПРО ГОЛОВНОГО АВТОРА

Ромаш Іван Романович
к.мед.н., доцент кафедри психіатрії, наркології та медичної психології. «Івано-Франківський національний медичний університет», Україна.
вул. Пилипа Орлика 5/7. 76010. Івано-Франківськ. Україна.
https://orcid.org/0000-0002-6591-6613
e-mail: iromashr@gmail.com

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